EMPOWERMENT
FAMILY, LIFESTYLE & SPIRITUAL MEDICINE LLC

Patient History Form

Please complete the form prior to your appointment. Once completed either send to us via the Spruce App or bring to your first appointment.

Full Name: Date of Birth:

Date:

Tell us about yourself:

Home situation (circle, or add in writing):

Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____)

Domestic partnership_____ Children _____ Are they healthy? _____

Employment:

Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation:

type of work/jobs:_____

Habits:

Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____
Do you use other tobacco products? No _____ Yes_____ If so, which products? _____

Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Do family or friends worry about your alcohol intake? _____

Do you use illicit drugs? No_____ Yes_____ If yes, please specify _____

Nutrition Habits:

1. How would you describe your eating habits?

2. Would you like to increase or decrease your weight?

3. Are you on a special diet (diabetic, low fat, vegetarian, etc.?)

Exercise Habits:

1. Do you exercise on a regular basis? (3 or more times/week for 20-30 minutes or more)

2. What type of exercise do you do?

3. If you do not exercise is it due to a particular reason (physical limitations, job, family life, etc.?)

Psycho/Social:

1. Do you feel like your life has a purpose?

2. How would you describe your overall mood?

3. Are you or have you undergone any major issues/stresses in your life?

4. If yes, how do you cope with these issues or stressors?

Allergies or Adverse Drug Reactions:
Please list drug and type of reaction

Past Medical History:
Please list other diseases from which you <u>currently</u> suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Surgical History:
Please list any surgeries (operations), reason for the surgery, and the date of the surgery:

Medications:

Prescription medications	Dose	How often taken

Non-prescription /Supplements (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

Family History:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

Do you have Health Care Surrogate/Health Care Directives? (If yes, please provide a copy at your first visit)

Immunizations: if YES, give approximate year given

Pneumococcal No_____ Yes_____
Hepatitis A No_____ Yes_____
Hepatitis B No_____ Yes_____
Tetanus No_____ Yes_____
Shingles No_____ Yes_____
HPV Vaccine No_____ Yes_____

Safety:

Do you use seatbelts? No_____ Yes_____

Transfusions:

Have you ever received a blood transfusion? No_____ Yes_____ When?_____

Please mark any symptoms you are currently experiencing or have experienced in the last month:

SYMPTOM REVIEW

Gastrointestinal

□ poor appetite
□ abdominal pain
□ indigestion
□ trouble swallowing
□ diarrhea
□ constipation
□ change in bowel habits
□ nausea or vomiting
□ rectal bleeding or blood in stools
□ history of liver disease or abnormal liver tests

Cardiovascular

□ chest pain
□ history of angina or heart attack
□ history of high blood pressure
□ history of irregular beat
□ history of poor circulation

Pulmonary/lungs

□ shortness of breath
□ persistent cough
□ coughing up blood
□ asthma or wheezing

Muscle/joint/bone

□ swelling of ankles or legs

pain, weakness or numbness in

□ arms or hands
□ back or hips
□ legs or feet
□ neck or shoulders

Neurologic

□ history of stroke
□ blackouts or loss of consciousness

General

□ weight gain/loss of 10+ lbs during last 6 months
□ poor sleep
□ fever
□ headache
□ depression

Eyes, ears, nose, throat

□ blurred vision
□ other change in vision
□ history of glaucoma or cataracts
□ loss of hearing
□ ringing in ears
□ sinus problems
□ hoarseness

Genitourinary

□ frequent or painful urination
□ blood in urine

Skin

□ itching
□ easy bruising
□ change in moles

Endocrine

□ history of diabetes
□ history of thyroid disease
□ change in tolerance to hot or cold weather
□ excessive thirst

Women only

□ abnormal Pap smear
□ bleeding between periods

date of last mammogram_____

Men only

□ PSA

Anything else?

□ Are you experiencing an unusually stressful situation?

□ Are there any specific personal issues you would like to bring up at the time of your visit?

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT